Paragard®
intrauterine copper contraceptive

Paragard
Specialty Pharmacy℠

WEB: ParagardAccessCenter.com
PHONE: 1-877-PARAGARD

Patient Authorization for Specialty Pharmacy

In accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules "HIPAA"), this Authorization authorizes my healthcare provider, health plan, and my pharmacy to disclose my health and personal information to CooperSurgical, Inc. and it's specialty pharmacy agents (and their affiliates, respective representatives, and agents) in furtherance of the below-stated authorized purposes.

Authorized Purposes

I understand that the selected specialty pharmacy will receive my health and personal information, which may include my name, address, patient insurance identification number, date of birth and other information necessary to obtain health insurance benefit verification for the following purposes: (1) the administration of CooperSurgical's Paragard Program; (2) to conduct benefit verification determining insurance reimbursement and coverage of Paragard; (3) to contact me to discuss any relevant co-pay; (4) bill the insurance company; (5) bill the applicable co-pay; (6) ship the unit to my healthcare provider; (7) to contact me by telephone in furtherance of conducting benefits verifications investigations and/or specialty pharmacy dispense; and (8) if I choose to self-pay for Paragard, to invoice me and to otherwise contact me to collect payment for the Paragard unit.

By signing the following form, I understand:

1. Once my healthcare provider gives the selected specialty pharmacy information about me based on this Authorization, my medical and health information may be subject to redisclosure and is no longer protected by federal privacy regulations.

   I further understand and agree that the selected specialty pharmacy may retain my medical and health information as disclosed under this Authorization after this Authorization expires.

   I also understand that in the event of an audit, and for purposes of such an audit, some information may also be disclosed to CooperSurgical, Inc., the manufacturer of Paragard, or its affiliates after this Authorization has expired, so long as the audit is for a period of time when this Authorization was in effect.
2. I may refuse to sign this Authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my healthcare provider; or to seek payment; or my eligibility for insurance benefits.
3. I may revoke my authorization at any time by providing a written notice of same to my healthcare provider, health plan and/or pharmacy that refers to (or with a copy of) this Authorization form, or to the selected specialty pharmacy. I understand that if I revoke this Authorization, it will not affect prior disclosures made to the selected specialty pharmacy and any use of such information by the selected specialty pharmacy in reliance of this Authorization. I understand that I have the right to receive a copy of this Authorization.
4. This Authorization shall expire one year after I have signed it, or upon revocation, whichever is earlier.

Signature of Patient or Legal Personal Representative: _____ **Date:** ____/____/____

Name of Patient or Legal Personal Representative: _____

(If Applicable) Description of Personal Representative's Authority to Sign for Patient:

_____

Please see Important Safety Information and Full Prescribing Information for Paragard at Paragard.com.

CooperSurgical®